INFORMATION

The California Academy of General Practice

Its Objectives and Development

THE California Academy of General Practice—with its 3,000 plus members and 30 county chapters—is the largest "special interest" group operating within the membership of the California Medical Association. Because of its considerable influence, its actions are of concern to every physician in the state.

Founded in 1948 as a chapter of the American Academy of General Practice, the group is completely independent of the California Medical Association. It does, however, recognize C.M.A. as the "parent" medical organization and will not consider anyone for membership until he is a C.M.A. member. It intentionally avoids participation in C.M.A. politics or duplication of C.M.A. activities and makes every effort to cooperate with the state medical society's policies. Medicine, already too splintered, has no room for medical organizations that place their own special interest above those of medicine as a whole.

Objectives

Before the Academy was organized the general practitioner had become a nonentity. If a doctor didn't specialize, he was a GP. That's all it required. Specialists had achieved considerable status through their own associations—GP's had none. No one was interested in developing the family doctor as a person *specifically* trained for a *specific* field. No one was trying to improve his training, let alone encourage anyone to enter the field. There were many instances of wholesale dropping of GP's from hospital staffs.

These were the conditions which led to the formation of the Academy. Its objectives were to develop a strong and representative organization exclusively for general practice; set and raise standards; improve hospital, public and professional relationships; improve postgraduate opportunities; and encourage general practice as a career. Some of these goals have virtually been achieved; others may take years to reach.

Membership Requirements

Academic entrance requirements are not as stringent as are those of the specialty boards, and 84 per cent of the applicants are ultimately accepted. Remaining a member, however, is another matter. Unlike any other medical group, the Academy elects members for only three year terms. At the end of that time a member must have completed 150 hours of postgraduate work. Last year 47 members were dropped for failure to keep up, and in some years the number has been as high as 100. The vast majority, however, do far more than the required amount of postgraduate work.

In spite of its rigidly enforced requirements, the Academy has had a substantial gain in its total membership. Growing at the rate of close to 200 new members per year it now represents well over 60 per cent of the family physicians.

Scientific Activities

The Academy's annual meeting is rated as one of the best scientific meetings in the country. It is kept clear of politics and draws from the finest teaching talent available in the United States. Local county chapters hold an additional 200 scientific meetings during the year—so combined with medical school and C.M.A. educational efforts, members have an abundance of excellent scientific programs to qualify for their continuing membership requirements.

Medical Schools

Medical schools have been severely criticized for not having GP's on their teaching faculties and for not exposing students to general practice. In California, however, the University of California, Stanford, U.C.L.A. and the University of Southern California work in close cooperation with the Academy-sponsored summer preceptorship program. Some 300 students have taken advantage of this program to spend two weeks of their vacation time with a physician in general practice. Such exposure has been responsible for a number of students choosing general practice as a career. Many have returned to practice with their preceptors. The program has been of equal value for weeding out the occasional student who intends to enter general practice but changes his mind after he realizes what is required to be a good GP.

Someday the Academy hopes to see the general practitioner have more of a voice in medical education within the schools. It feels this will come as the standards of general practice continue to rise and as general practice becomes better defined.

Residency Training

The average medical student, looking towards general practice, worries and wonders about the training he may be getting to prepare him to be a

well-qualified GP. While there is, as yet, no complete agreement over what constitutes the best GP residency, a growing number of members feel that if general practice residencies are to attract top caliber students, they must be equal or better than the training programs offered for the major specialties. They feel that the absolute minimum for anyone entering general practice today should be a one-year internship plus two years of a well-organized, well-supervised general practice residency. It has been shown that GP's trained under such programs have no problem with hospital privileges and are able to provide their patients with a wide range of service of excellent quality. This view is supported by the fact that many one-year programs are unfilled, while many of the better, lower pay two-year programs have more qualified applicants than they can possibly consider.

Another encouraging factor is that the residency applicants, in a growing number of cases, are of an exceedingly high quality. In one major university both the top and next to top men in the class are taking general practice residencies despite the fact that in their school a scant 20 per cent of the class is going into general practice. If enough effort is given to quality the matter of quantity will eventually take care of itself.

Hospitals

The Academy has conducted intensive studies of hospital staffs and hospital relationships. One of these completed in 1956 showed that less than 6 per cent of the general practitioners in California had any complaints as to their hospital privileges. This same study repeated this year produced *identical* results. Another study of all California hospitals showed less than 3 per cent had no GP's on their staffs, and this included the university teaching hospitals. This and other studies show that the GP is more than holding his own in hospitals.

The Academy completely supports the Joint Commission on Accreditation of Hospitals, C.M.A.'s Guiding Principles, and has recently sponsored conferences on medical audits in an effort to get them introduced in California. It feels that in many cases hospital controls have been too lax and that there is a great deal of room for staff education and improvement. However, it wants rules to be applied to all physicians on the staff and vigorously opposes hospital regulations which give special privileges to favored groups. Applying this policy to itself, it has been equally quick to oppose some hospitals which have required that GP's on their staff be Academy members.

Members are expected to take part in local hospital affairs and current statistics show that they are most active. One out of three members serves on hospital committees and 15 per cent hold key roles as chief of staff or head a department. Many of these are in large, metropolitan hospitals where specialists may outnumber GP's.

Public and Professional Relations

Virtually every Academy activity is concerned with improving the public and professional relations of the profession. The Academy distributes a large number of its own publications, publishes a bi-monthly bulletin, and supplies articles for a number of other medical journals. One of its stories published last year on the British Health System as viewed by the GP was reprinted for a circulation of over five million copies.

In a step toward improving interprofessional relationships the Academy recently sponsored a one-day conference on hospital medical audits. The conference was so successful that two more are planned for Los Angeles and San Francisco this November, this time drawing in specialists and hospital administrators.

The Internist as the Family Doctor

The Academy recognizes the value of the internist as a consultant and also the fact that many internists are serving as family physicians. However, it doesn't look upon the internist as a "competitor," realizing that he is often forced into the role of family physician not by choice but because of the relatively large number of internists and the shortage of GP's.

Some internists' groups have run into strong opposition from the Academy over the matter of fees. The Academy supports the basic principle of the California Medical Association that fee schedules, when they exist, must be based on *service* rather than a variety of factors including the physician's experience, overhead and training. The physician should be compensated for his training but this compensation should come when this special training is applied to the patient and not on routine cases where the patient receives no particular benefit by virtue of being treated by a specialist.

Attitude Toward Surgical Privileges

The Academy agrees with the American College of Surgeons that there is room for improving surgical care. It does, however, disagree with the college's methods of going about this. While the Academy fully recognizes the importance of adequate formal training, it insists that standards and supervision must apply to all doctors on the staff, regardless of qualifications. Board certification of a surgeon may give a certain assurance of his ex-

posure to technical training, but unfortunately, it does not insure his integrity. His "certification" is not subject to review nor has it ever been removed once it has been received. A board-certified surgeon may do operations poorly or unnecessarily or do "ghost" operations or split fees just as any other physician may do. He should be subject to the same rules as anyone else.

The Academy does feel that there are some very strong arguments for training the physician so that he will be able to provide his patients with both medical and surgical care for the more frequently seen conditions. Since many conditions can be treated either medically or surgically, the physician who does both is in an ideal position to make a proper diagnosis and to choose the treatment that has the best chance of success.

Who Runs the Academy?

The principal governing body is a Congress of Delegates made up of representatives from county chapters. It is a forum before which the problems of the general practitioner are discussed. One of its chief responsibilities is the election of a president and an 18-man board of directors who have the major responsibility for Academy policies. The board in turn employs a full-time executive secretary as the executive officer of the association. He is assisted by two other employees in carrying out the day to day operations. Five standing committees assist the board: constitution, hospital, education, program and public and professional relations.

Board of General Practice

The Academy, both nationally and in California, has opposed the formation of a board of general practice. The concept of a board violates one of its basic precepts, i.e., each physician should be given the opportunity to demonstrate his competence, and not be judged primarily on the basis of certification or membership in any specialty society. There is nothing to prevent the Academy from accomplishing everything for general practice that a board might achieve—especially in relation to improving standards of general practice residencies. The physician who is well-trained and practices within his limitations seldom gets into difficulties regardless of certification.

The Future of General Practice

The need for more GP's is the most critical problem facing the Academy. Its long range attack on this problem is to concentrate on improving the quality of residency training available. In the meantime it feels that general practice has much on its side. The place of the GP in the hospital has improved considerably; the incomes for GP's have become adequate; the GP is able to exert his full time skill in the practice of medicine and surgery, and he is winning the respect and confidence of the medical schools through preceptorship programs and serious concentration on postgraduate medical training.

CLARENCE T. HALBURG, M.D., *Immediate Past President*
BURT L. DAVIS, *President*
JOHN A. C. LELAND, *President-Elect*
WILLIAM W. ROGERS, *Executive Secretary*
CALIFORNIA ACADEMY OF GENERAL PRACTICE
Nine First Street, San Francisco 5.

Costs of Hospitalization

A Report by the Bureau of Research and Planning

RESOLUTION No. 93, introduced at the 1961 Annual Meeting of the California Medical Association House of Delegates, requested a study of hospital costs and current trends in hospital management. Its primary purpose, as reflected in the "whereas" portions of the resolution, was to differentiate between the costs of hospital and professional services in the spectrum of health care protection in order to provide the medical profession and the public with greater insight into some of the factors contributing to increasing expenditures for health care.

A few statistics will demonstrate the central role of the hospital in the provision and financing of health care services. According to the Department of Commerce, 26 cents, the largest proportion of every dollar spent in 1960 for private health care, went to hospitals.[6] In California, 1.8 million persons spent over 11.5 million days in acute, short-term, general nonfederal hospitals during a one-year period 1958-1959. The 1.8 million represented 90 per cent of admissions to all types of hospitals and accounted for 30 per cent of all patient days. It has been estimated that the cost to the public of these services was $438 million, or 58 per cent, of all nonfederal expenditures for hospitalized care. According to *Hospitals*, the average length of stay in

Approved by the Council of the California Medical Association, September 23, 1961.

TABLE 1.—*Average Daily Service Charges—U. S. and California*

Type of Accommodations	United States	California
Single bed	$20.00	$28.70
Two-bed	17.20	24.30
Three-bed	16.00	23.00
Four-bed	15.80	22.30
Five-bed	15.00	22.50
Six or more	15.10	18.80